

March 27, 1992

ATTACHMENT 1

NATIONAL HCFA 1500 CLAIM FORM SAMPLE

PICA										HEALTH INSURANCE CLAIM FORM										PICA									
1 MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER										14 INSURED'S ID NUMBER										FOR PROGRAM IN ITEM 11									
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)										3 PATIENT'S BIRTH DATE										4 INSURED'S NAME (Last Name, First Name, Middle Initial)									
Recipient, Im A.										MM DD YY M SEX F										234567890									
5 PATIENT'S ADDRESS (No. Street)										6 PATIENT RELATIONSHIP TO INSURED										7 INSURED'S ADDRESS (No. Street)									
609 Willow St.										Self Spouse Child Other																			
CITY										8 PATIENT STATUS										CITY									
Anytown										Single Married Other										STATE									
STATE										Employed Full-Time Student Part-Time Student										STATE									
WI																													
ZIP CODE										TELEPHONE (Include Area Code)										ZIP CODE									
55555										(XXX) XXX-XXXX										()									
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10 IS PATIENT'S CONDITION RELATED TO										11 INSURED'S POLICY GROUP OR FECA NUMBER									
OI-P										a. EMPLOYMENT? (CURRENT OR PREVIOUS)										a. INSURED'S DATE OF BIRTH									
										YES NO										MM DD YY M SEX F									
12 OTHER INSURED'S POLICY OR GROUP NUMBER										b. AUTO ACCIDENT? PLACE (State)										b. EMPLOYER'S NAME OR SCHOOL NAME									
										YES NO																			
13 OTHER INSURED'S DATE OF BIRTH										c. OTHER ACCIDENT?										c. INSURANCE PLAN NAME OR PROGRAM NAME									
MM DD YY M SEX F										YES NO																			
14 EMPLOYER'S NAME OR SCHOOL NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN?									
																				YES NO If yes, return to and complete item 9 a-d									
d. INSURANCE PLAN NAME OR PROGRAM NAME										12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE										13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE									
										I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
SIGNED										DATE										SIGNED									
14 DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)										15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE										16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION									
MM DD YY										MM DD YY										FROM MM DD YY TO MM DD YY									
17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE										17a. I.D. NUMBER OF REFERRING PHYSICIAN										18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
I.M. Referring										12345678										FROM MM DD YY TO MM DD YY									
19 RESERVED FOR LOCAL USE										20 OUTSIDE LAB? \$ CHARGES										22 MEDICAID RESUBMISSION CODE ORIGINAL REF NO									
										YES NO										23 PRIOR AUTHORIZATION NUMBER									
																				1234567									
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)										24 A DATE(S) OF SERVICE										B C D E F G H I J K									
										From To										Place of Service Type of Service PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT HCPCS MODIFIER DIAGNOSIS CODE \$ CHARGES DAYS OR UNITS EPSDT Family Plan EMG COB RESERVED FOR LOCAL USE									
										MM DD YY MM DD YY										7 1 W9529 1 XX XX 2 11223344									
										03 02 92 17 7 1 W9523 1 XX XX 2 11223344																			
										03 15 92 23 29 7 1 W9523 1 XX XX 9 11223344																			
										03 21 92 7 1 W9512 1 XX XX 1 11223344																			
										03 16 92 7 1 W9512 1 XX XX 1 11223344																			
25 FEDERAL TAX I.D. NUMBER										26 PATIENT'S ACCOUNT NO										27 ACCEPT ASSIGNMENT?									
										1234JED										YES NO									
28 TOTAL CHARGE										29 AMOUNT PAID										30 BALANCE DUE									
\$ XXX XX										\$ XX XX										\$ XXX XX									
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof)										32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)										33 PHYSICIAN'S SUPPLIER'S BILLING NAME ADDRESS, ZIP CODE									
I.M. Authorized																				I.M. Billing									
MM/DD/YY																				1 W. Williams									
SIGNED										DATE										Anytown, WI 55555									
																				87654321									